Strengthening the Safety Net in Detroit and Wayne County

Report of the Detroit Health Care Stabilization Workgroup

Introduction

Early in the Granholm Administration, the Governor met with the Chief Executive Officers of the three Detroit health care systems – Detroit Medical Center (DMC), Henry Ford Health System (HFHS), and St. John Health System (SJHS). At their request, the Governor convened the Detroit Health Care Stabilization Workgroup (DHCSW) to assess and plan solutions for the crisis in Detroit health care. This is the report of that workgroup.

The workgroup's first step examined safety net models from other urban areas (Chicago, Denver and Saint Louis). The workgroup learned several valuable lessons from health authorities in other cities.

Lesson 1. Safety net services are focused on the Medicaid and uninsured populations.

Lesson 2. The authority relied on Medicaid as a good payer and attempted to attract commercial clients.

Lesson 3. The authority took several years to develop. Problems with payment and delivery systems can not be solved over night. Chicago took 15 years to develop its current publicly based health system.

Lesson 4. The authority provided access to the full continuum of care for its clients. Denver Health, for example has 10 community health centers, 15 school based Health Centers, a 349 bed hospital, 5 dental clinics, the Public health Department, an HMO, substance abuse and mental treatment capacity, and a poison center. (See Appendix 1)

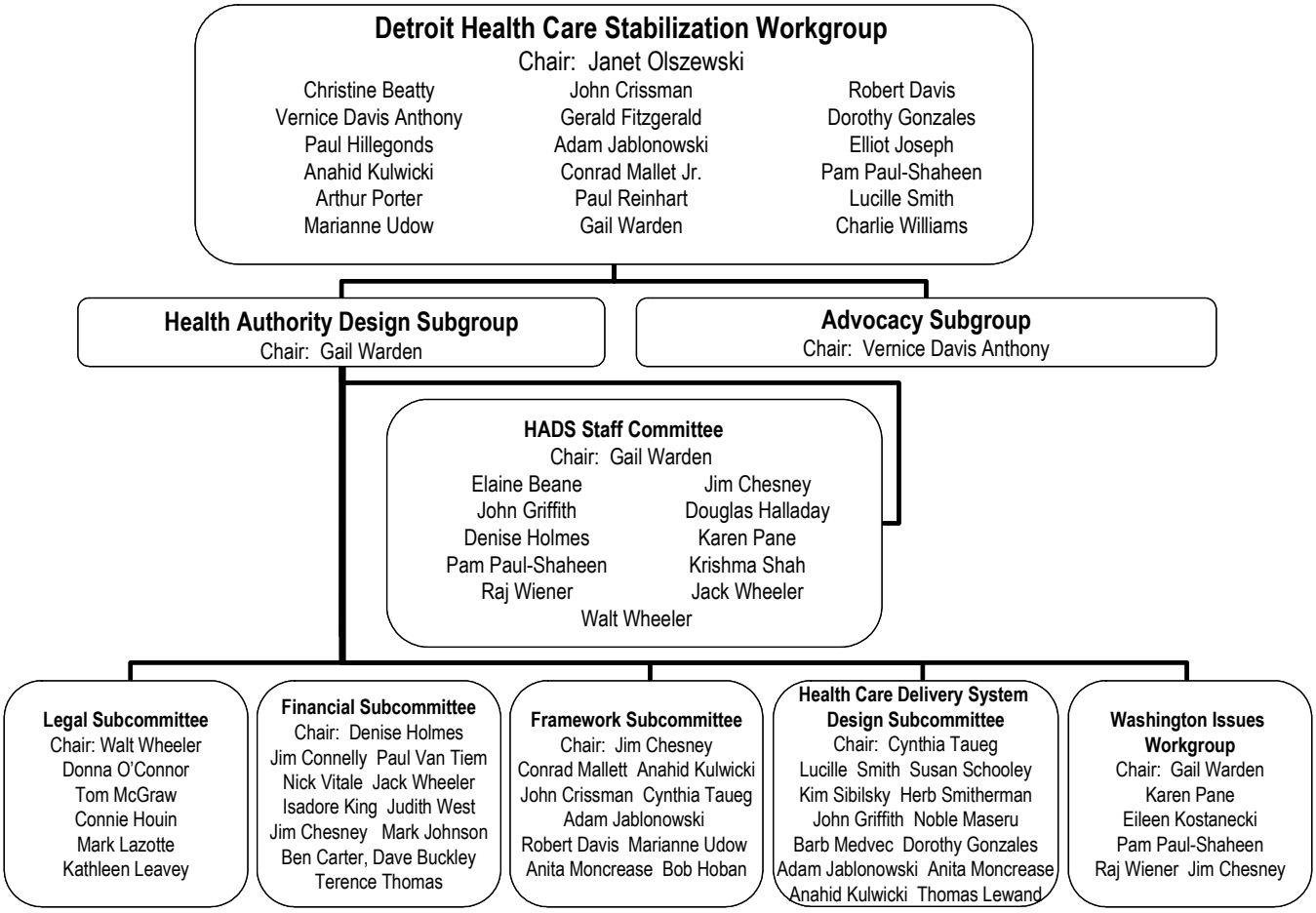
Lesson 5. Prevention and primary care are very important.

Lesson 6. Care management is a core function for the authority. Authority purchasing power must be used to build a more efficient, administratively simple, and integrated delivery system.

Lesson 7. The authority should have a medical school affiliation.

The second step built a structure that transformed stakeholder opinions into a series of recommendations. As shown in Figure 1, the DHCSW acquired the services of ten full time staff and forty workgroup members who gave time to meet once or twice a week for the past two months.

Figure 1. Organizational Structure Health Authority Design Subgroup



Problem Statement

Unlike Michigan, Wayne County (especially Detroit) has experienced a continuous decline in population over the past several decades.

The challenges of managing a shrinking community are multiplied when significant economic constraints and poor health status accompany the shrinkage, as is the case in Detroit and Wayne County. Poor economic and health status are most vividly demonstrated when comparing Detroit and Michigan. For example, 59% of Detroit's population has an income below the 200% federal poverty level, as compared to 26% of Michigan's population. Male life expectancy in the state is 73.5, compared to 64.5 in Detroit.

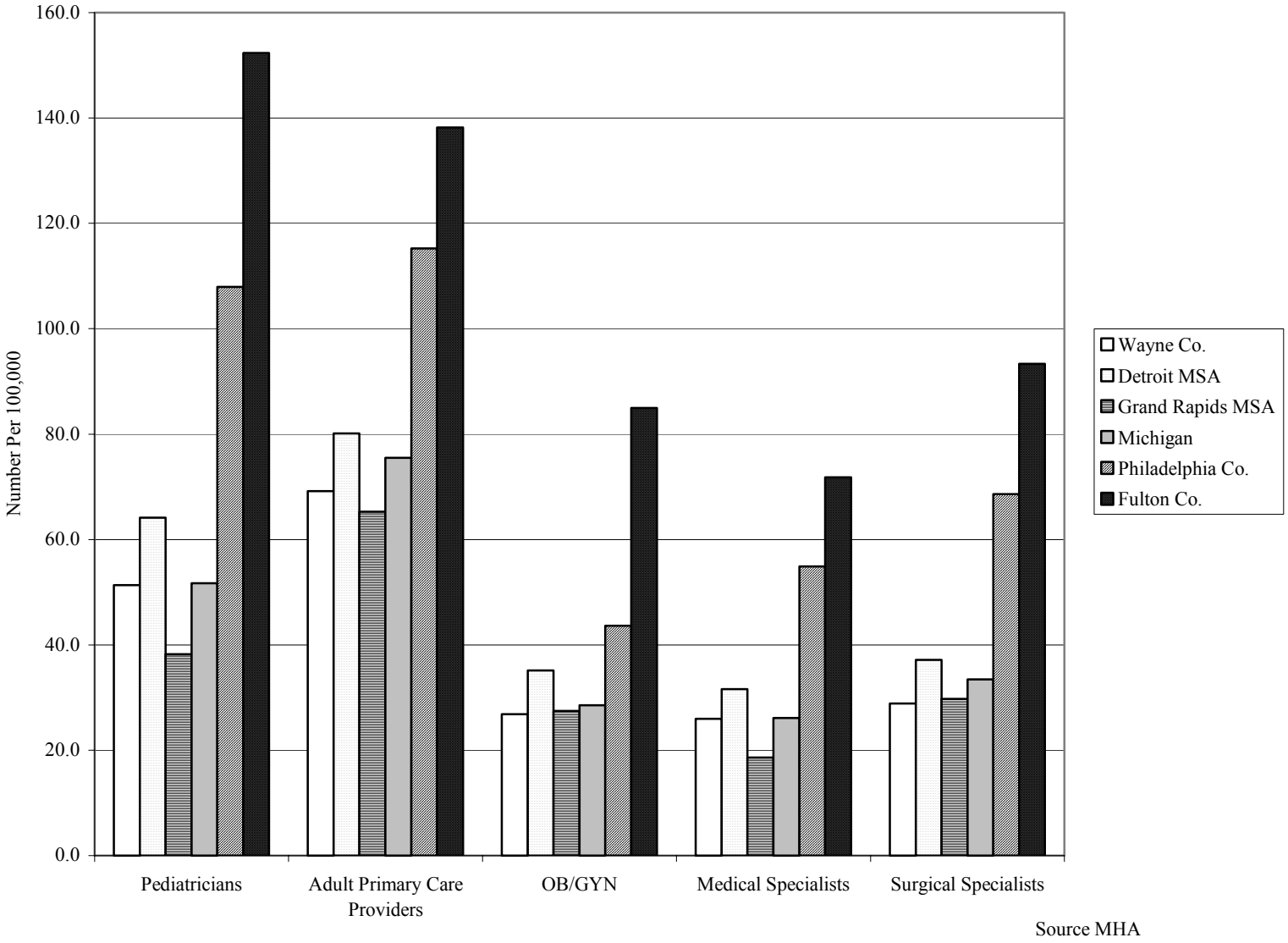
The implications of high rates of poverty and other related economic circumstances for the health care system are profound. Income is inversely related to health status: the lower one's income, the higher the incidence and severity of illness, injury, or death. In addition, low-income persons are more likely to be uninsured or to rely on public sources of financing for health services. High unemployment and a high incidence of self-employment exacerbate this problem.

Detroit's health care infrastructure is eroding. Since 1998, twenty primary care clinics have closed. Since 1997, four hospitals have closed and 1,220 beds and 4,468 full time jobs were lost. An additional Detroit hospital is projected to close before the end of the year, which will reduce capacity by 300 beds.

Detroit's health care infrastructure has suffered because of physician flight out of the city and the city's inability to attract its fair share of funding for Federally-Qualified Health Centers (FQHC). An additional infrastructure problem is the lack of a coordinated plan to care for the Medicaid and uninsured population.

Figure 2 documents the lack of primary care physicians and other types of specialists in Detroit, compared to other communities.

Figure 2. Physician Concentrations by Type by Area

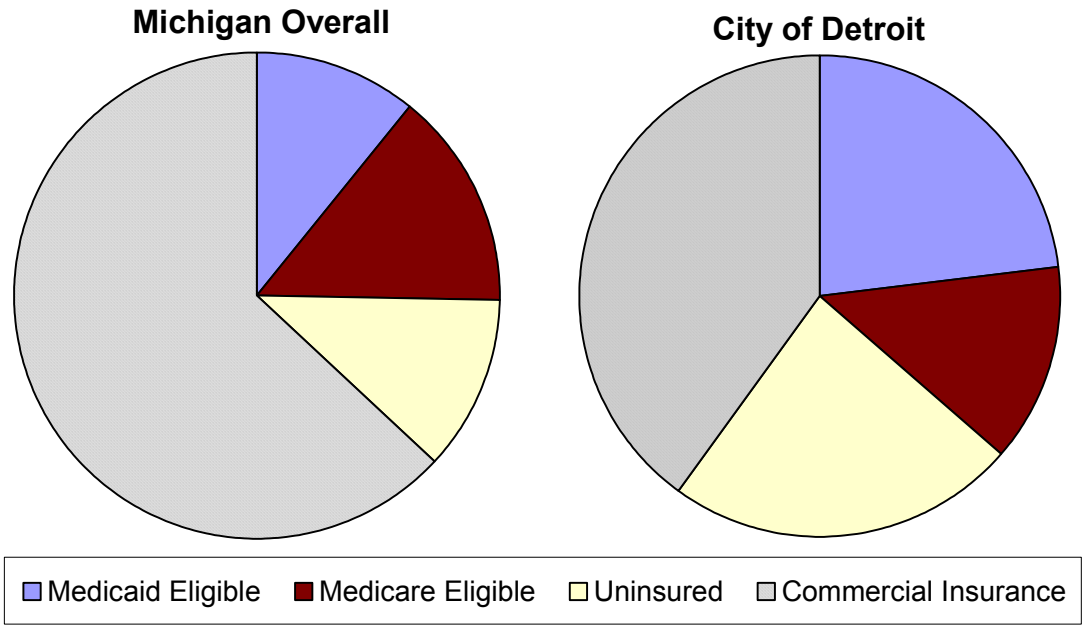


Source MHA

The loss of primary care capacity has left Detroit with inadequate resources in this crucial area. One way to measure this problem is to examine the number of people in medically under served areas. Fifty-nine percent of Detroit's population resides in federally designated areas of medical under service, as compared to 33% of Michigan residents.

Detroit and other similar cities across the nation have increasingly fragile health care systems because there is a concentration of limited resource patients in these communities. In Michigan 22.5% are either uninsured or Medicaid eligible. The corresponding figure in Detroit is more than double, with 52.5 % either uninsured or Medicaid eligible. Only 35 % of Detroit's residents have commercial insurance, compared to 63% statewide. (see Figure 3)

Figure 3. Insurance Coverage Breakdown for Michigan and the City of Detroit.



Instability is caused by the concentration of uninsured and Medicaid eligible residents in Wayne County. A solution must finance a safety net that provides high quality, cost-effective health services for people who are not eligible for insurance and people eligible for state or county insurance programs. In Wayne County nearly seven hundred thousand people fit into this category.

The population estimate is based on the following:

- 280,000 – Uninsured (Wayne County, including Detroit)
- 390,000 – Medicaid
- 25,000 – Plus Care

695,000 Wayne County Total

Medicaid is under funded.
Michigan had the lowest Medicaid health plan capitation rate in the country in 2001. The Urban Institute estimates the state-wide per member per month Medicaid rate for 2001 was $105.35. Michigan's rate was almost 50% lower than the Median national state rate of $150.60. The highest rate in the country was $209.34, nearly double the Michigan rate and 69% higher than the Medicare managed care rate for that state.

Michigan Medicaid increased capitation rates in 2003, but it is likely that rates remain below those paid by other states.

The estimated shortfall in funding for the provision of care to the Medicaid and low income uninsured populations by providers in Wayne County is estimated to be $300 million. The under funding estimate includes:

- The losses on patient care for the four major hospital systems (the Detroit Medical Center, Henry Ford Health System, St. John and Oakwood) providing care in Detroit/Wayne County are estimated at $261million for FY02.

- The HMOs serving Medicaid clients in Detroit/Wayne County lost a combined $9.6 million in calendar year 2001.

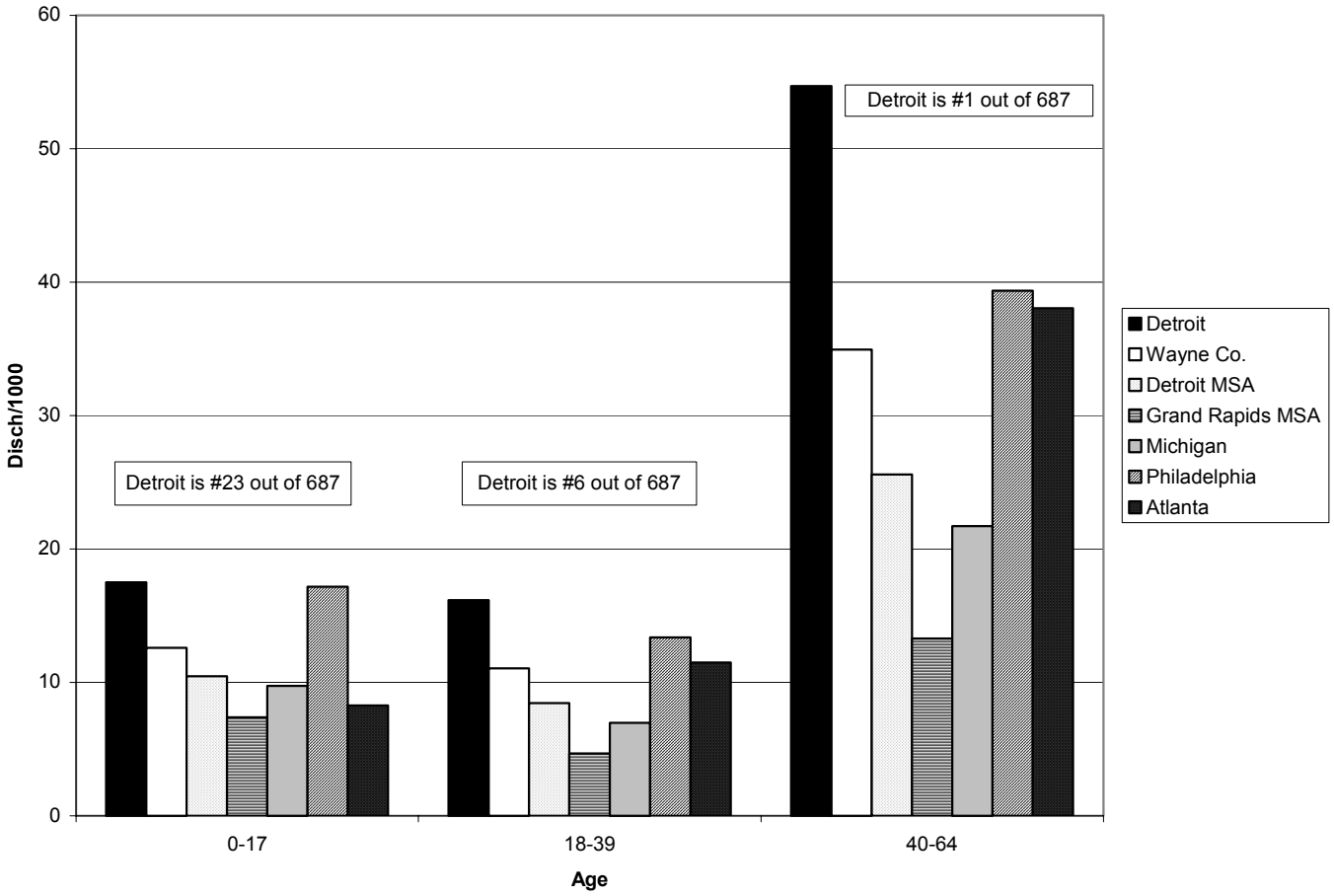
- Billing revenue and Detroit Medical Center subsidies did not cover $17 million of care provided to Medicaid and low income uninsured people by physicians associated with Wayne State University.

The chronic under funding of Medicaid, cuts imposed by the Balanced Budget Act, declining investment income, loss of commercial payments, and the concentration of Medicaid recipients in Detroit has resulted in declining financial margins. The data show that Detroit hospitals had worse margins than their counterparts in Michigan in 2001. Patient margin is the percentage difference between net patient revenue and total expenses. Detroit hospitals were paid nearly 8% less than their expenses, compared with roughly a 3% loss in other areas of the state. In other communities with higher commercial payer mix, and healthier populations, providers are better able to cope with the chronic under funding.

Underpayment has resulted in several of the Wayne County based Medicaid Qualified Health Plans coming under State supervision in order to continue operation. The largest Medicaid health plan in Wayne County (The Wellness Plan) is under state supervision and the County's largest Medicaid delivery system (DMC) recently entered into an agreement to receive a $50 million bridge payment from the state, county and city, which will not be repeated.

Under funding of health care produces a system that is both inefficient and unsustainable. Investing in chronic disease care management is impossible in an under funded system, despite the overwhelming evidence that such management is cost effective. Physician flight, clinic closures as well as hospital closures and financial losses provide clear evidence for the unsustainability of the current system. Examples of inefficiencies include the over use of emergency rooms or the lack of coordinated care for the resource limited patient. Preventable admissions are an indicator of a health system that is not providing the best care for its patients. Detroit has a high rate of preventable admissions as indicated in Figure 4.

Figure 4. **Preventable/Avoidable Hospitalizations by Age Category by Area**
Source: MHA



Stabilizing the health care system in Detroit/Wayne County requires at least an additional $246 million annually.

The most promising solution to the under funding problem is creating a mechanism that leverages current local governmental spending with federal matching funds under the intergovernmental transfer mechanism. The challenge is to raise $90 million that could be matched by $110 million from the federal government.

These leveraged funds then can be transferred into higher payments for ambulatory and hospital care. Table 1 summarizes how funding mechanisms can contribute to solving the under funding of services to the Medicaid and uninsured population.

Table 1
Summary of Savings/Funding Sources

	Description	**Amount (In Millions)**
1.	FY02 Funding Shortfall	**$300.0**
2.	FY03 Additional Funding—Net of Assessment Payments	
	Hospital QAAP*	**- $30.0**
	HMO QAAP*	**- $24.0**
3.	**Net FY 03 Funding Shortfall**	**$246.0**

*QAAP, Quality Assurance Assessment Program, uses funds provided by hospitals and HMOs as match to earn additional federal Medicaid funds. Legislation establishing this program expires in 2005, but can be re-authorized by the legislature.

The problems identified in Wayne County have significant implication for the surrounding counties. People seeking care readily cross city and county boundaries.

Recommendations

What can be done? Strengthening the safety net requires participation of all public and private sectors. A strategy that matches public and private abilities with responsibilities must be implemented.

The Authority must strengthen the safety-net health care delivery system. The health care safety net consists of those organizations and programs, in both the public and private sectors, that have a legal obligation or a commitment to provide direct health care services to the uninsured, underinsured, and other under served groups. Broadly defined, these organizations include: public and private hospitals that provide a disproportionate share of services to under served groups; community and migrant health centers; public health departments (both state and local) which directly provide safety net services; organizations funded by federal categorical programs such as Title X family planning clinics, Title V prenatal care programs, and Title XV breast and cervical cancer screening program providers; and other community-based organizations that provide uncompensated or reduced-price services.

Government's ability to provide public health core services and pay for care must be linked with the creation of a public entity that:

- coordinates the public and private components of health care services.
- leverages Medicaid funds to provide insurance benefits to the uninsured.
- expands preventive and primary care using programs such as Federally-Qualified Health Centers.

Providers must be prepared to reorganize their delivery systems in a way that will:

1. Improve access.
2. Enhance primary care capacity.
3. Improve efficiency.
4. Deliver high quality care through integrated partnerships that provide care for the uninsured.

Recommendation 1

The Michigan should develop a public-private strategy to improve its Medicaid rates to a nationally recognized benchmark.

Medicaid spending is a function of the population covered, benefits included and rates paid. Federal regulations requiring actuarial soundness will most likely require the state to increase managed care rates. In the interim, the state must use every effort to leverage federal Medicaid funds.

To the extent that Medicaid pays less than the cost of the health care services it purchases, other payers – individuals and businesses - end up with higher health care costs, in payments to health care providers or in insurance rates. This problem is particularly severe in Wayne County with its large Medicaid and uninsured populations, a scarcity of providers, and an uncoordinated approach to providing health care.

Medicare is the key benchmark against which Medicaid payment rates can be compared. Medicaid payments to health care providers now average less than 75% of what Medicare would pay for the same services. Michigan Medicaid HMO rates are only 70% of Medicare rates, even after accounting for the recent adjustments for the Quality Assurance Assessment.

The Michigan legislature once recognized in law that Medicare was the standard for Medicaid payment rates. However, Michigan Medicaid payment rates have not kept up. Michigan Medicaid is now short of the Medicare standard by $950 million dollars (about $410 million in state general funds and $540 million in federal matching funds.) At a time when there is a shortfall across the entire state budget, re-achieving the Medicare benchmark would be a fiscal challenge. However, without some fiscal relief, Medicaid will inevitably contribute to an even greater extent to the instability of the Michigan health care sector. The impact will be felt most directly by hospitals and doctors who serve Medicaid patients, including their Medicaid patients who are enrolled in HMOs.

A time of fiscal stress presents an opportunity to explore alternative strategies that might improve the Medicaid service delivery and financing system. Important principles in developing a better Medicaid financing and service delivery system include payments tied to an accepted benchmark such as Medicare and reorganization of delivery models.

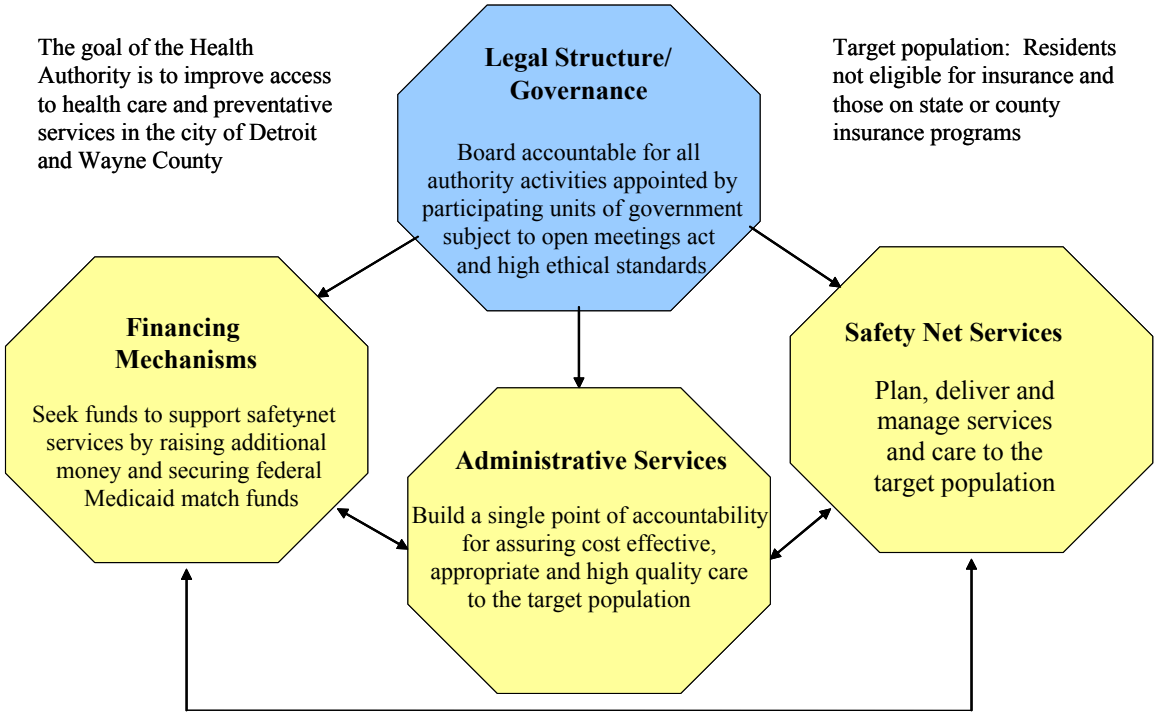
Recommendation 2

A Detroit Wayne County Health Authority should immediately be established to provide safety net services, facilitate care coordination, maximize revenues and enhance efficiency.

In order to accomplish this, the Authority should:

- provide for improved access to health care services through an integrated and coordinated system of preventive, primary, and specialty healthcare facilities and services whether owned and/or contracted.
- develop a strategic plan for the health care and preventive health services of those individuals served by the authority.
- aggressively seek additional government and private funds for safety net services.
- receive and disburse public and private funds for the provision of safety net services rendered.
- strive to assure that persons receive appropriate and high quality health care services in a way that will maximize efficiency and efficacy.

Figure 5. Detroit Wayne County Health Authority Framework



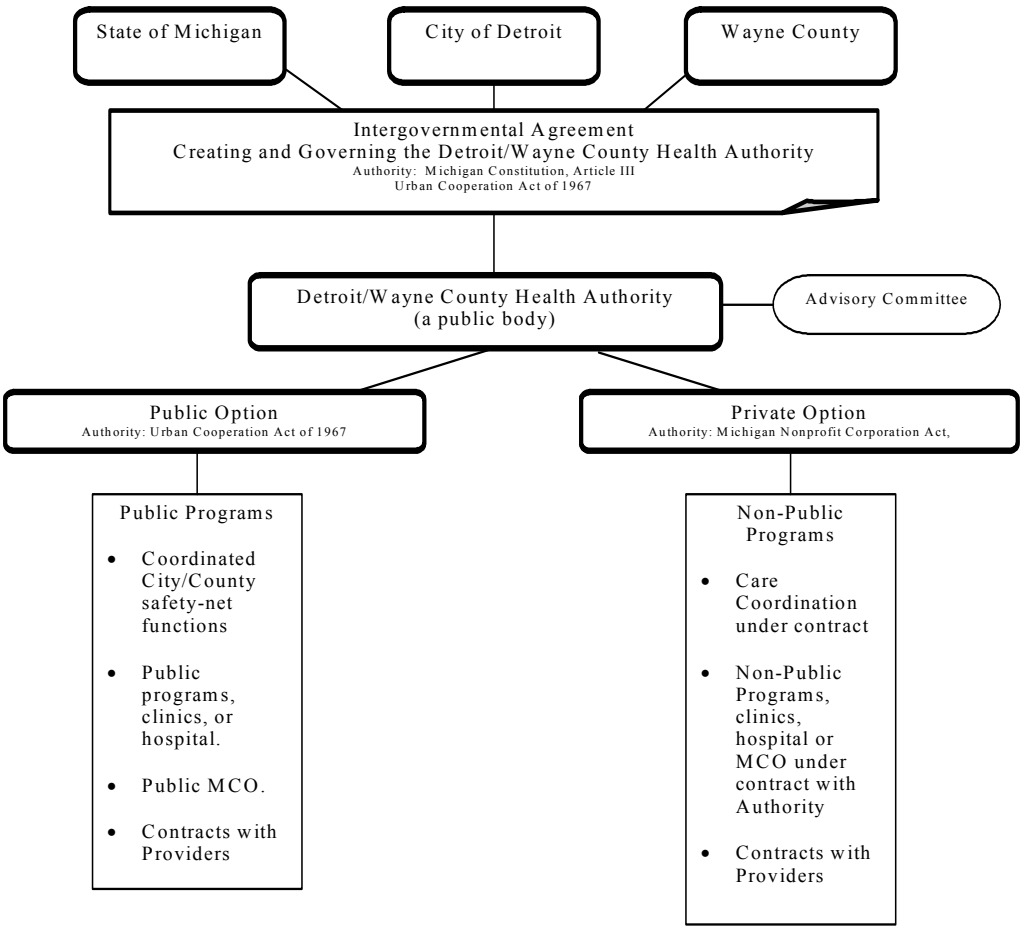
Recommendation 2.1

The DWCHA should be established through an intergovernmental agreement executed between the City of Detroit, County of Wayne, and State of Michigan.

The state, county, and city should enter into an intergovernmental agreement ("Agreement"), using the authority of the Urban Cooperation Act of 1967 ("Act"). The Urban Cooperation Act permits different levels of government to cooperate in addressing problems jointly using existing authority. The Agreement will create a health authority ("Authority"), with the powers provided for in the Act and as set forth in the Agreement. The execution of the intergovernmental agreement will form the Detroit Wayne County Health Authority, a public body; the Authority could create additional public and private entities, as needed. It could be expanded to include additional Southeast Michigan units of government.

This approach has considerable flexibility to address both near-term issues, and those longer-term issues that have been identified to date.

Figure 6.
Health Authority Legal Structure



There are several key advantages to creating the Authority through an Agreement:

1. *Speed.* The Authority can be established as soon as the parties agree upon the terms of the Agreement. The Detroit City Council and Wayne County Board of Commissioners must approve the Agreement, but no voter approval or legislation is required. The governor, mayor and county executive must also execute the Agreement. This will help meet the goal of having the Authority up and running by year-end.

2. *Efficiency:* The Authority will eliminate duplication of public and private effort and resources through coordinated strategic planning that aligns the interests of the public and private sections, and through the transfer of service functions to the Authority.

3. *Flexibility.* The Act gives the three units of government great flexibility and discretion in structuring their powers, duties, and responsibilities under the Agreement. While the Authority under the Agreement can undertake most of the functions identified by the subcommittees in the short term, the structure can also evolve in phases to meet the future needs of the Authority, as circumstances require. Audit, FOIA, and Open Meetings Act provisions will apply to the Authority. The Authority can apply conflict of interest rules and procedures. Separate operating divisions could be created for different programs. Advisory boards or committees could be established for the Authority as a whole or for particular programs (including representation from providers, consumers or businesses, if desired). The Authority could also be expanded to eventually include all of Southeast Michigan.

4. *Powers.* The Act permits the creation of a "separate administrative or legal entity" to carry out the functions of the Authority. A separate administrative entity would be a public body corporate, and the Agreement would define various powers of the Authority under this structure. Among these powers would be the ability to enter into contracts; employ staff; acquire, hold and dispose of property; and own and/or operate a hospital or clinics

5. *Financial.* The Authority would be a public body with the ability to receive public funds. The Authority could issue bonds for public improvements in its own name, but only subject to limitations under the Act. The Authority may share in tax revenues of governmental units, but subject to a formula in the Act; it would have no separate taxing authority.

Recommendation 2.2

The Detroit Wayne County Health Authority must focus initially on developing a more effective care management, payment, and delivery system to enhance primary and preventive care and reduce costs.

The Authority can achieve a more rational payment and delivery system through efficient, better administrative services and an integrated delivery system, which emphasizes primary and preventive services and chronic disease management.

The goal is to provide a seamless system of care through a more effective and efficient delivery system that will improve the health of the public, decrease the cost of the care and add value to the areas health service delivery system. This will be done by:

- Establishing a defined and accountable set of resources and services to care for the target population.
- Expanding the number and location of primary care access points to serve the target population.
- Assigning every enrolled client a primary care medical home which will facilitate access to the full continuum of care based on patient needs so clients receive the right level of care at the right time and place.
- Coordinating and integrating service delivery between and among authority health care providers to eliminate fragmentation and reduce cost.
- Providing care management and referral services as a core component of the delivery system to facilitate access to a full range of culturally competent preventative health, medical and non-medical services. All clients will be enrolled and care-tracked.
- A delivery system design that is able to enhance federal and other funding and reduce duplication.

A. Efficiency

Three types of efficiency improvements are possible. The first is an efficiency gain improving preventive care by eliminating unnecessary disease though immunization and improved health education. The second is improved efficiency due to managing care away from hospital Emergency Departments.

In addition, the HMOs with Medicaid contracts have a higher average cost for emergency room and out-of-area services—commercial HMOs average 5.1% of costs for these services while the HMOs with Medicaid contracts average 7.7%. If the Medicaid HMOs could reduce ER usage to the commercial level **an additional $24.5 million could be saved**. Presumably, the Authority could encourage FQHCs and other ambulatory care providers to adopt after-hour clinics and evening/weekend office hours to provide a cost-effective alternative to emergency room services.

Efficiency can also be achieved by care management that emphases primary and preventive services and manages the referral process. This efficiency requires improved

information systems such as an electronic patient clearinghouse and the development of delivery networks.

B. Safety Net Delivery System

The Authority should develop a care management system to coordinate the provision of primary care, preventive, and public health services, as well as hospital care, specialty services, behavioral health and community social services and outreach. In order to ensure cultural competence and access to these services, the Authority will coordinate as needed with continuum of care linkages, including long-term care, Public Health Departments, Wayne State University School of Medicine, other colleges of health professions, volunteer based clinics, local government, and other private providers. The Authority will provide or contract for these services as needed.

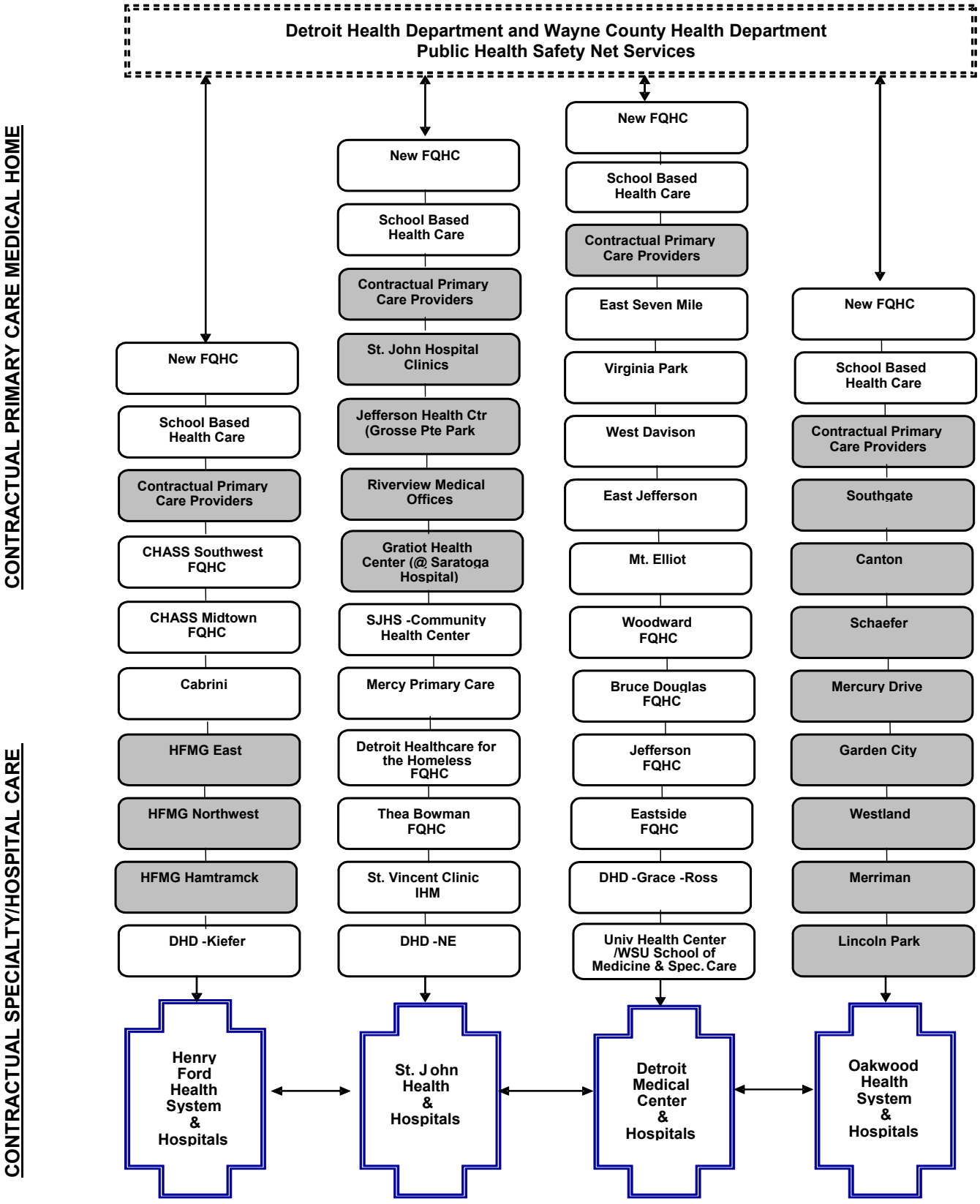
The Authority should develop a data system to enroll and track patients and their care. This includes management and clinical information to support real time decision making based on quality data.

Patients will be enrolled and care will be coordinated through a defined process such as used by the Voices of Detroit Initiative (VODI). Services will include primary care, ambulatory care, specialty care, ancillary and diagnostic services, and inpatient services. The assignment of all clients to a primary care medical home will act as the foundation of the Health Authority's care model. Also, services will be coordinated and integrated within the Health Authority provider network. The current "Detroit/Wayne County Existing Primary Care Access Points," *could* represent a care delivery starting point by working with and through the current known, sustainable service providers and networks committed to care for residents of Detroit and Wayne County. Through these resources, the Health Authority will develop a service plan that will assess and determine the type and location of providers, resources, and services needed to implement an optimal care model for this population.

Such a starting point would not preclude the inclusion of other providers as needed or deemed appropriate by the Health Authority. Rather it allows for a fairly expedient service delivery start up. All providers will serve clients under the Authority's umbrella. This will be done through contracts, ownership and/or other arrangements consistent with state, local, and federal guidelines/regulations and as needed to assure access to the full continuum of care.

Figure 7 illustrates existing health care providers networks in Detroit and Wayne County which care for this target population.

Figure 7. Detroit/Wayne County Existing & Potential Primary Care Access Points



SHADED AREAS HAVE NO FORMAL POLICY TO SERVE THE UNINSURED

The authority will incorporate the following guidelines.

- **Provision of Services:** Establish and manage a health care delivery system through ownership and/or provider contracts based on quality and cost. In order to assure the stability of the delivery system, the Authority will make every effort to provide timely payments to providers of care that adequately cover the cost of efficient and appropriate care. Funds will follow services provided to the eligible population. Administrative costs will be minimized through establishment of uniform billing procedures and reducing and/or controlling the number of contracted entities.
- **Accessibility:** The Authority will seek to provide a medical home for all the eligible/target population. Services will be provided at convenient hours and in locations accessible to the population such as evening and Saturday provision of primary care. Provider and service contracts will reflect this provision as needed.
- **Quality:** The Authority will assure best practice benchmarks will be used by all providers, which will support efficiency and cost effective care. This includes adherence to industry accreditation standards, Medicaid regulations, and other regulations and guidelines specific to a profession or provider agency.
- **Client Acceptability:** Programs will be established to regularly assess and respond to client, patient, and provider satisfaction including issues of cultural competence.
- **Fees:** A fee structure will be established that includes a minimum payment for services by all patients that is consistent with Medicaid and any other federal guidelines/requirements. Fees may be charged for all medical services including primary care visits, emergency room visits, and pharmaceuticals. Patient fees are to be collected at the time of service unless otherwise indicated. All funds collected will be accounted for to the Authority.
- **Prevention:** The Authority will make health promotion and disease prevention a priority in the design.
- **Accountability:** The Authority will be accountable to the City of Detroit, Wayne County and the State of Michigan, businesses, public and private sector interests and other stakeholders to fulfill its obligations and conduct business in an effective, efficient, ethical, and moral manner. The Authority will assure accountability of provider performance which may include audits, quality assurance, and compliance activities as needed.
- **Coordination/Integration:** The Authority will provide coordination services to integrate the service delivery providers, reduce or eliminate fragmentation, and increase cost effectiveness. Coordination activities include but are not limited to membership enrollment, facilitation of access to the full continuum of care through referral mechanisms, and effective and timely billing systems. The delivery system seeks to provide clients a service delivery standard that maximizes appropriateness of intervention and level of care.

Recommendation 2.3

One of the first priorities of the Detroit Wayne County Health Authority is to raise additional revenues to stabilize the delivery system and improve care.

The most promising solution to the under funding problem is creating a mechanism that leverages current local governmental spending with federal matching funds under the intergovernmental transfer mechanism. The challenge is to raise $90 million that could be matched by $110 million from the federal government. These leveraged funds then can be transferred into higher payments for ambulatory and hospital care.

Other sources of potential funding to be considered for match might be:

- Additional state, county, or city funds devoted to the target population.
- Current Detroit/Wayne County public health spending could be used to make a DSH payment that would generate federal match for these dollars. The recently submitted Health Insurance Flexibility and Accountability Act (HIFA) waiver generates significant new DSH capacity.
- Wayne State University general fund monies could also be used to generate match through a DSH payment if room exists under Michigan's DSH ceiling.

Other strategies to maximize Medicaid revenues include:

- Maximizing Medicaid eligibility and enrollment by the low income uninsured.
- Increasing the capacity for Medicaid payments to a public Managed Care Organization (MCO) by creating a public MCO to serve Wayne County residents.
- Increasing the capacity to generate HMO QAAP revenue by expanding enrollment of Wayne County Medicaid recipients into managed care plans.
- Creating a public hospital which could be eligible for the 175% Disproportionate Share Hospital (DSH) Payment , which requires Congressional action to extend.

The Health Authority must pursue financing mechanisms to begin operation (estimated start up costs are between $500,000 and $1,000,000). Potential sources include:

- Grants from private foundations;
- State of Michigan application for a State Insurance Planning Grant;
- Applying for a federal demonstration grant from Health and Human Services;
- A membership model in which participants pay annual dues to the authority.

Recommendation 2.4

The Detroit Wayne County Health Authority should establish and manage a health care and preventive services delivery system through ownership and/or contracts with the goal of improving the health of the public, while enhancing quality and reducing cost.

The Health Authority provides an opportunity to improve performance in the delivery of health care services and health outcomes to the Medicaid and uninsured population. In addition, the Health Authority can:

- Stabilize provider relationships and support for the program.
- Streamline processes that will reduce costs in an economic environment where the program continues to be inadequately funded to support the level of care the Medicaid-eligible and uninsured populations deserve.
- Build a mechanism to establish coordinated care delivery across the continuum of care.

There are nine Medicaid HMOs under contract with the state operating in Detroit/Wayne County. Their individual administrative overhead ranges from a low of 8.3% to a high of 14.7%. In aggregate their administrative overhead is 10.2%, which is 1.6% above the average of 8.6% for commercial HMOs operating in Detroit/Wayne County. By reducing administrative overhead costs to the average of the commercial HMOs, there is an opportunity for **administrative savings of $5.4 million**.

The Health Authority can play a unique role by redefining the underlying approach to how preventive and primary care is provided in Wayne County. The Health Authority can bring focus to improvements in quality and cost that are impossible in the current system. Among the expected improvements are:

- Improved administrative efficiencies.
- Maximizing federal match funds.
- Increasing quality by extending best clinical practices across the delivery system with a goal of reducing overuse, misuse and waste.
- Enhanced funding for services such as School-Based Health Centers and other community-based services.

In order to receive Medicaid funds that cover the cost of providing patient care, the Health Authority must either directly deliver patient services or contract for delivery of patient services. A guiding principle of the Health Authority is that funds must follow the care delivered.

In order to assure the stability of the delivery system, the Authority will make every effort to provide timely payments to providers of care that adequately covers the cost of efficient and appropriate care. Administrative costs will be minimized through establishment of uniform billing procedures and reducing and/or controlling the number of contracted entities. This function requires an electronic patient information

clearinghouse that captures data on enrollment, insurance status, and health care services delivered.

Once the Authority is legally established, it will be developed in four Phases.

Phase 1
The Authority can contract with the state for Administrative tasks related to planning of a more effective Medicaid payment and delivery system in Wayne County. Examples of activities during this phase include:

- Develop an implementation timeline.
- Provide assistance to VODI so that it can continue coordinating Primary care
- development and chronic disease management of the uninsured and enroll and track care delivered to the uninsured.
- Working with elected officials and the Greater Detroit Area Health Council, explore strategies for regional expansion.
- Develop a primary case management program under contract with the DCH for the Wayne County/Detroit Medicaid fee-for-service population and direct this population into more cost effective care settings.
- Participate in Medicaid eligibility determination work under agreement with the Family Independence Agency in order to earlier identify and enroll qualified people into Medicaid.
- Work closely with officials at HHS and HRSA to increase the number of FQHCs, identify other funding opportunities beyond the federal match and explore Medicaid policy changes that support the work of the Authority.
- Conduct a gap analysis for primary care and develop a strategy to attract primary care services to Wayne County and Detroit.
- Conduct a gap analysis for coordinated specialty care and develop a strategy to attract specialty care services to Wayne County and Detroit.

Phase 2:
During this phase the Authority will work with organizations that have matchable funds to both maximize these funds and design an effective payment mechanism for the distribution of raised funds. The Authority could begin to assume the responsibility for services offered through Public Health clinics. Some examples of tasks under this phase include:

- Identify and quantify local sources of spending that can qualify for Medicaid federal matching payments and gain agreement with the local entity generating the dollars to use the money for a Medicaid matching payment.
- Work with the Department of Community Health to match these funds and assure the matched funds are used to provide enhanced reimbursement to Wayne County/Detroit providers.
- Contingent upon the Authority raising additional revenues, it will become the repository for funds spent by the Detroit Health Department for safety net services and for the funds spent by Wayne County Plus Care and Health Choice on safety net services, and receive hospital DSH payments from the hospitals in Wayne County and distribute these funds to providers for caring for the low income uninsured.

Phase 3:
Once Phases 1 and 2 are complete, the Authority should assume a greater role in the management of the delivery of care provided to the population served by the Authority. For example, providers could assign their fee-for-service payment to the authority in exchange for payment using the Authority payment system. The Authority could begin to explore the efficacy of bringing hospitals, other clinics, and QHP delivery systems into the Authority. Guidelines for making this decision include: a) Acquisition of an operating facility should enhance the assets and improve the capital structure of the Authority, and b) Ownership is necessary to increase funds available to the Authority.

Phase 4:
In Phase 4, the Authority could become the single managed Care Organization for Wayne County. In this phase, the Authority would pay and contract with providers directly. Contracted entities could include current Medicaid QHP delivery systems. The Authority could own or contract for key managed care services or functions such as member service, claims processing, care management, and provider relations as well as operate facilities, if advisable. During this phase the Authority will work with the Safety Net Systems to develop a comprehensive chronic disease management program using state of the art Information, Communications Technology and apply to the CMS or other funding sources for a demonstration grant to build this system.

Implementation Action Steps

- Broad communication of this report to all stakeholders and the community.
- Establish the Authority
  - Execute Agreement
  - Appoint a governing board
  - Hire Interim CEO
- Convene advisory groups and continue work on financing mechanisms, administrative structure and safety-network development.
- Continue to develop and test feasibility of financing mechanisms
- Fundraising for initial start up costs ($500,000-$1,000,000)
  - Philanthropy.
  - State Planning Grant.
  - Federal Demonstration Project.
- Create a(n):
  - Business Plan.
  - Organizational structure and hired staff.
  - Information system to enroll, verify insurance and track care delivered.
  - Performance Management System.

- Create guidelines for contracting with safety networks.
  - Shared enrollment, verification, financial, and care tracking data.
  - Adherence to a core set of care principles, policies and procedures.

Next legal steps: The state, county and city governments should immediately begin negotiating the terms of the Agreement. The recent inter-local agreement used to create the Detroit Area Regional Transportation Authority ("DARTA") is a good model to begin negotiations between the parties. To frame the early discussions, the following is an outline of some issues that should be addressed in the Agreement:

a. The purpose of the Authority.
b. Powers of the Authority—for example, the power to own real and personal property in its own name, incur debts, enter contracts, employ staff, issue bonds, etc.
c. Description of Authority—for example, its geographic boundaries and the population to be served.
d. Determine the extent to which current responsibilities of sate city or county governments are transferred to the Authority.
e. Determination of whether subunits are desired for certain programs
f. Board composition—for example, the number of board members, how board members are chosen or removed.
g. Operation of the governing board—for example, creation of bylaws and procedure for amending bylaws, requirements for meetings, quorum and voting.
h. Day-to-day operation of Authority—for example, the type and number of officers and how the officers are chosen and removed; compensation of officers.
i. Duration of the Agreement, the timing and method for terminating the Agreement and the disposition of assets following termination.

j. Development of a comprehensive health care plan for the population in the geographic region.
k. Methods of funding the Authority.
l. Assets to be transferred by the three units of government into the Authority.
m. Functions to be transferred by the three units of government into the Authority, such as the safety net function.
n. Staff to be transferred by the three units of government into the Authority and the responsibility for continuing civil service rules and collective bargaining agreements.
o. Establish user fees—for example, co-payments.
p. Creation of advisory committee and composition of committee
q. Establish policies to govern ethical and conflict of interest issues.
r. Compliance with FOIA and Open Meetings Act.
s. Establish methods for overseeing the activities of the Authority through financial audits, measuring provider and patient satisfaction, a compliance program and measuring the quality of health care.
t. Establish a budget.
u. Establish method for disbursing funds.

List of Appendices and Attachments

Denver Health: A Model for the Integration of a Public Hospital and Community Health Center
HMA Summary of Background Issues
DHCSW Organizational Chart
DHCSW Roster
HADS Subcommittee Roster

Gabow, P., Eisert, S. and Wright, R. 2003. Denver Health: A Model for the Integration of a Public Hospital and Community Health Centers. *Annals of Internal Medicine.* Vol. 138:143-149

Denver Health: A Model for the Integration of a Public Hospital and Community Health Centers

Patricia Gabow, MD; Sheri Eisert, PhD; and Richard Wright, MD

Two major pillars of the United States' safety net system are urban public hospitals and community health centers. Their common mission is to care for the uninsured and other vulnerable populations. However, in most communities these important components of the safety net remain organizationally and functionally separate, which inhibits the continuum of care and creates substantial inefficiencies. Denver Health is a long-standing vertically and horizontally integrated system for vulnerable populations. The integration benefits the patient and the system and serves as a model for the U.S. safety net. This paper outlines the benefits of integration to the patient, provider, and health system, using data from the National Association of Public Hospitals and Health Systems, the Bureau of Primary Health Care, and Denver Health.

Ann Intern Med. 2003;138:143-149. www.annals.org

For author affiliations, see end of text.

Summary of Background Issues
Pertaining to the Financial Condition of Health Care
Institutions and Organizations in the City of Detroit

July 21, 2003

This paper has been prepared at the request of the Department of Community Health for the Detroit Health Care Stabilization Workgroup. Its purpose is to provide a broad, high-level overview of issues that are affecting the condition and stability of the health care system in the City of Detroit.

The paper consists of a series of highly general observations regarding factors that are contributing to the current set of health system problems in the City. For the most part, the paper contains little that will be surprising or new to informed readers. Nevertheless, it is worthwhile to recapitulate in a comprehensive way the many interrelated trends that underlie these problems.

I. Population: Detroit's population is shrinking

Unlike its surrounding communities, the City of Detroit has experienced a continuous decline in population over the past several decades. The following table describes the trend during a recent period.

Table 1: Population Trends

	1990	2000	% change
Detroit	1,027,974	951,270	-7.5%
Wayne County	2,111,687	2,061,162	-2.4%
Oakland County	1,083,592	1,194,156	10.2%
Macomb County	714,400	788,149	10.3%

In general, the social and political problems posed in connection with the management of a shrinking community are far more challenging than the problems posed in connection with rapid growth. Broadly speaking, the costs of basic infrastructure of large urban areas (police and fire, roads, water, etc.) are largely fixed and reducing infrastructure capacity and cost is extremely difficult from many different points of view. This is largely true of health care infrastructure as well.

As an example, a shrinking community may have excess physical capacity and its associated excess cost, and bringing capacity into proper balance can be a difficult and wrenching process.

II. Economic Status: Detroit's population is economically disadvantaged

The challenges of managing a shrinking community are multiplied when the shrinkage is accompanied by significant economic constraints. As with population, the City of Detroit has, by most measures, not kept pace with its surrounding communities in terms of economics. The following table illustrates this problem.

Table 2: Median Household Income, 1999	
Wayne County	$ 40,776
Oakland County	$ 61,907
Macomb County	$ 52,102
Detroit	$ 29,526

The implications of high rates of poverty and other related economic circumstances for the health care system are profound. For example, income has been widely demonstrated to inversely relate to health status: the lower one's income, the more likely the incidence of illness, injury, or death. In addition, low-income persons are more likely to be uninsured or to rely on public sources of financing for health services.

III. Health Status: Detroit's population has sharply higher rates of illness, severity, and mortality

The health status of residents of Detroit is worse on nearly all measures than the average for Michigan, and is significantly worse than that of residents of Oakland, Macomb and even Wayne County at large. Table 3 illustrates a selection of health status measures in which Detroit residents fare much worse than the state's average.

Table 3: Health Status Measures in Which Detroit Residents Fare Much Worse than the State Average 2000-2001
Hospitalizations for Asthma
Incidence of HIV
Incidence of Hepatitis B
Death from Heart Disease, age 35-64
Death from Cancer, age 35-64
Infant Mortality
Incidence of Late Stage Prostate Cancer
Incidence of Invasive Cervical Cancer
Death from Breast Cancer
Incidence of Late Stage Breast Cancer

These and other health status problems place greater demands on the health care system and generate higher costs.

IV. Hospital Capacity: Detroit's hospital capacity has decreased significantly

Detroit's hospital resources have been significantly reduced over the past two decades. This is due partly to the correction of historically high levels of excess capacity, partly to the reduction in the City's population, and partly to the financial pressure experienced by institutions with particularly difficult patient mix and other problems. It is likely that the current level of hospital capacity is within the range of appropriateness for the City.

Nineteen hospitals closed between 1980 and 1997, removing 4,679 licensed beds and 14,109 full time jobs from Detroit. Since 1997, four more hospitals closed and an additional 1,220 beds and 4,468 full time jobs were lost.

Table 4: Recent Hospital Closures in Detroit

Hospital	Year Closed	# Beds Closed	# FTEs Lost
Saratoga Community Hospital	1998	203	587
Sinai Hospital of Detroit	1999	623	2,270
New Center Hospital	1999	146	410
Mercy Hospital	2000	248	1,201
TOTAL		1,220	4,468

Despite these closures, occupancy at Detroit hospitals has remained steady at about 75% for the past five years.

One effect of these most recent closures may have been to concentrate the uncompensated burden on the remaining hospitals without a corresponding transfer of commercial and other higher-paying business.

It may be observed that, with respect to process, the reduction in hospital capacity in the City has not been accomplished in an orderly or planned way, and the collection of facilities that are in existence today may or may not constitute an optimal configuration from the community's point of view.

V. Hospital Utilization Patterns: Detroit and non-Detroit residents increasingly look to non-Detroit hospitals for services

The patterns of use for hospital services by residents of both Detroit and its surrounding communities have continued to change. Specifically, though Detroit residents still receive most of their hospital services from Detroit hospitals, an increasing proportion of Detroit residents look to non-Detroit hospitals for care. Similarly, though most non-Detroit residents receive hospital care at non-Detroit hospitals, a fair number do not. But that number has declined significantly over the past few years.

Table 5: Patient Origin Patterns/Inpatient 1996 – 2001		
Detroit Residents	discharged from Detroit hospital	discharged from non-Detroit hospital
hospitalized in 1996	82%	18%
hospitalized in 2001	75%	25%
Non-Detroit Residents		
hospitalized in 1996	18%	82%
hospitalized in 2001	13%	87%

These changing patterns are not favorable for Detroit hospitals. Taken together, they describe a deteriorating market in general, and one might conjecture that the admissions lost to Detroit hospitals are more likely to involve a commercially-insured patient than an uninsured patient.

VI. Primary Care Resources: Detroit's primary care resources are not adequate

Detroit's primary care resources are not adequate. One way to measure this problem is to examine the number of medically underserved areas and populations within the City. According to one recent study, 59% of the City's population resides in federally-designated areas of medical underservice, a figure far in excess of surrounding communities.

Table 6: Percent of Population Medically Underserved, 2000	
Wayne County	59.10%
Oakland County	8.30%
Macomb County	0%
Michigan Average	32.90%

This problem affects both insured and uninsured people, but is particularly severe for the uninsured, whose options for obtaining services are much more limited.

It is widely held that inadequate primary care manifests itself in preventable hospitalizations. For example, according to the Michigan Department of Community Health, "*Preventable hospitalizations are those for which timely and effective ambulatory care can help reduce the risks for common problems such as asthma, diabetes or dehydration. High rates of preventable hospitalizations in a community may be an indicator of a lack of or failure of prevention efforts, a primary care resource shortage,*

poor performance of primary health care delivery systems, or other factors that create barriers to obtaining timely and effective care."

Preventable hospitalizations in Detroit children are primarily attributed to asthma, pneumonia, and kidney or ear infections. In adults, Detroit's preventable hospitalizations are most often for asthma, diabetes, pneumonia, and congestive heart failure. All these conditions respond to aggressive outpatient care and self-management, and all exacerbate and result in preventable hospitalizations when primary care and self-management are lacking.

Table 7 illustrates the high degree to which Detroit residents in every age group experience preventable hospitalizations.

Table 7: Preventable Hospitalizations Per 10,000 Population, 2000

	Detroit	Wayne County	Oakland County	Macomb County	Genesee County	Kent County	Michigan
all ages	411	336	200	242	288	153	235
< 18	180	134	79	84	132	81	98
18-24	121	92	53	55	85	37	57
25-44	240	159	67	71	131	60	91
45-64	589	401	172	206	303	150	234
65-74	1117	898	576	652	810	492	652
75-84	1720	1494	1173	1300	1436	847	1206
85>	2897	2679	2346	2419	2468	1465	2074

Most observers also believe that inadequate access to primary care leads to lower health outcomes and inappropriate use of other system resources, especially hospital emergency departments. In addition, though few broad-based studies have been conducted on the subject, it is very likely that inadequate primary care resources also lead to inappropriate use of specialist physician services. In some cases, the services of these physicians will be used unnecessarily; in others, patients who need such services will never get them.

The problem of inadequate primary care is also illustrated by the fact that the penetration of FQHCs in Detroit is just one third of that in Chicago or Baltimore, and half of Detroit's clinics only operate on a part-time basis. In the past five years, there have been no new applications from Detroit for FQHC sites or look-alike sites, either of which can operate multiple clinics. In that same period just two new clinics have been approved through the existing sites, and one clinic application was rejected.

It is also worth noting that both the higher cost of care for Detroit residents (as compared to other Southeast Michigan residents) and the higher number of per capita hospital discharges for Detroiters are viewed by some as an indication of a lack of efficiency in

Detroit hospitals. However, given the relatively lower lengths of stay in Detroit hospitals, it is more likely that inadequate primary care generates increased and more costly hospital use. (See Section XI)

VII. Coverage Patterns in the Community: The patterns of commercial and public coverage, along with the level of uninsured patients, is extraordinarily unfavorable to Detroit hospitals

Putting aside the mix of patients at any specific hospital, the patterns of coverage for the population of Detroit is extremely unfavorable for Detroit hospitals. This pattern is described in the following table.

Table 8: Community Coverage Mix, 2000

	Population	Medicaid Eligible		Medicare Eligible		Uninsured		Comm Insurance	
		#	%	#	%	#	%	#	%
Detroit	951,000	300,000	31.5%	113,553	11.9%	200,000	21.0%	337,447	35.5%
Wayne County	2,144,372	358,582	17.4%	304,362	14.4%	280,675	13.1%	1,200,753	56.0%
Oakland County	1,185,768	61,690	5.2%	152,385	12.9%	117,604	10.0%	854,089	72.0%
Macomb County	740,337	41,888	5.3%	120,732	15.2%	75,496	10.2%	502,221	68.0%
Michigan	9,815,878	1,066,131	10.7%	1,433,750	14.5%	1,166,724	11.8%	6,149,273	63.0%

Both the large number of uninsured and the low level of commercial coverage are striking. Given this mix, it is difficult to see how hospitals serving Detroit residents can maintain the financial condition of their institutions.

Moreover, the commercial health insurance environment in Southeast Michigan is dominated by a small number of large payers and a small number of large purchasers. These payers and purchasers are thus able to exercise significant restraint on payment and expenditure levels, limiting the ability of providers to make up deficits arising out of publicly-financed business or service to the uninsured.

VIII. Payer Mix for Individual Hospitals: The mix of commercial and public payments, along with the level of uninsured patients, is unfavorable for Detroit hospitals

The pattern of coverage described above produces a payer mix at hospitals that is unfavorable for Detroit hospitals. These hospitals will clearly have more difficulty in managing the burden of uncompensated care.

Table 9: Patient Mix as Percent of Patient Services 12/01 – 6/02				
	All Detroit Hospitals	Beaumont	Oakwood	Spectrum
Commercial, self-pay or Medicare, %	69.53	96.01	79.72	82.03
Medicaid, SMP or uncompensated care, %	30.47	3.99	20.28	17.97

IX. Cost of Care: The cost of care for residents of Detroit is higher than in other places in Michigan

The cost of care is higher in Detroit than elsewhere. This may reflect two conditions: the lower health status of Detroit residents combined with the lack of primary care, which results in more hospitalizations, and the higher cost of doing business in the City.

Table 10: Selected Per Capita Cost Comparisons						
	1998 Medicare rates	2004 Medicare projected rates	1999 AFDC Medicaid, inpatient services	1999 AFDC Medicaid, all services	1999 BAD non-dual Medicaid, inpatient services	1999 BAD non-dual all services
Wayne County	$ 651.00	$ 742.00	$ 65.29	$ 106.78	$ 405.23	$ 602.79
Oakland County	$ 614.00	$ 700.00	$ 60.91	$ 105.50	$ 365.25	$ 626.05
Macomb County	$ 604.00	$ 688.00	$ 47.25	$ 97.24	$ 273.32	$ 518.68
State Average	$ 523.00	na	$ 39.37	$ 85.31	$ 226.47	$ 452.37

This pattern is entirely consistent with the experience of hospitals in large urban areas throughout the country.

X. Quality of Care in Hospitals: The quality of care at Detroit hospitals is comparable to other hospitals throughout Michigan

There is no evidence that the quality of care rendered in Detroit hospitals is significantly different from that rendered in other similarly situated institutions elsewhere. As one example, data from the Michigan Hospital Association's *2003 Michigan Hospitals Profiles Project* (not attached to this paper, but readily available from MHA) shows that, in almost all respects, Detroit hospitals perform at levels comparable to similar hospitals throughout the state.

This observation suggests that, despite the financial pressure under which they operate, Detroit hospital managers have maintained a sharp focus on patient care issues. However, there is presumably a limit to the ability of managers to maintain this focus in the face of deteriorating economics.

XI. Efficiency of Operation in Hospitals: The efficiency of operation at Detroit hospitals is comparable to other hospitals throughout Michigan and elsewhere

There is no evidence that the efficiency with which Detroit hospitals operate is significantly different from the levels of efficiency attained at other hospitals. To illustrate, the following table shows various standard measures of operating efficiency for a sample of Michigan and out-of-state hospitals.

Table 11: Hospital Efficiency Indicators, 2001

	Spectrum	Hurley	U of M	Receiving	Harper	H. Ford	Sinai	Gr. Baltimore M.C.	Johns Hopkins	Chicago Med Ctr	Mt Sinai Chicago
admissions per FTE	7.64	8.82	4.56	8.48	9.89	5.62	9.27	8.4	6.01	3.8	9.6
outpatient visits per FTE	54.1	167.9	173.5	88.1	88.1	174.5	87.1	59.5	43	98.9	118.1

Further, while hospitalizations occur with more frequency for Detroit residents, Table 11 illustrates that the length of stay in Detroit hospitals is actually lower than in the surrounding counties and compared to several other urban counties.

Table 12: Average Hospital Length of Stay, 2000

Detroit	Wayne Co.	Oakland Co.	Macomb Co.	Ingham Co.	Kent Co.	Genesee Co.	Michigan
5.76	5.81	5.92	5.84	5.95	5.30	5.82	5.45

Indeed, given the financial pressure under which they operate, one would expect Detroit hospitals to exhibit comparatively high levels of efficiency.

XII. Medicaid Funding: Medicaid funding, both for health plans and FFS, is not adequate

Hospitals and other providers in Detroit rely far more heavily on the Medicaid program for funding than elsewhere. Roughly 30% of Detroit residents are enrolled in Medicaid. Unlike many other communities, where Medicaid is a payer of secondary importance, the role of Medicaid in Detroit is crucial. For this reason, the financial contribution of Medicaid in Detroit must be adequate to help sustain the system.

Medicaid funding levels in Detroit are not adequate to sustain the system as it is presently organized. One recent study calculated that Medicaid FFS payment rates across the state are at 60%-70% of Medicare rates, rates that are generally regarded as approximating cost for hospitals and as reasonable payment for physicians. Funding for health plans serving Medicaid clients is also inadequate. FY 2004 health plan rates are estimated to be at 86% of Medicaid FFS. Plans serving Medicaid clients in Southeast Michigan have combined losses of $150-200 million over the past five years, leading to the insolvency of some plans and state supervision of others.

XIII. Other Observations and Conclusions

It is difficult to avoid the conclusion that the key factor underlying the present challenges in Detroit is the coverage and payer mix. More specifically, it is the combination of Detroit's extraordinarily large number of uninsured persons, the heavy reliance on Medicaid and Medicare, and the relative absence of commercial payers that underlies the problem.

This suggests the following specific conclusions with regard to financing:

- Many of the trends noted above should be regarded as irreversible in the short term. There is little likelihood that population trends, income trends, and trends in health status will change substantially anytime soon. Similarly, the trend towards use of non-Detroit hospitals seems unlikely to change. This implies that the payer mix problem will not be solved without intervention.
- The payer mix situation requires that the role of Medicaid in Detroit be recognized as fundamentally different than it is anywhere else in the state. Through its policies and funding levels, Medicaid must act to maintain the financial stability of key health institutions and organizations in Detroit.
- The magnitude of the problem in Detroit, i.e., the funding deficit, in economic terms, is roughly $150-200 million. Medicaid health plan rates should be at least 10% higher to return those organizations to financial health, an adjustment that would require $50 million. Hospital systems require $75-100 million in additional funding to overcome deficits and begin generating surpluses. Organizing and expanding the ambulatory care system will require $25 million or less. These figures should be evaluated in the context of Michigan's overall health system (more than $50 billion), the state budget ($40 billion), and the Medicaid budget ($6 billion).
- It is important not to overlook the effects on non-profit health care institutions of the recent dramatic reversals in investment returns in U.S. financial markets. These reversals have had significant effects on non-patient care revenues and on hospital retirement and pension expenses. While this has affected all hospitals, not just those in Detroit, its impact is greater on hospitals in weak condition to begin with.

The extraordinarily high number of uninsured persons in Detroit is a problem of special importance. With respect to this problem, it may be observed that:

- The key objective for the uninsured in Detroit is to find ways of bringing these individuals into organized systems of care.
- In pursuing this, the main goal should be to improve health outcomes and to foster more appropriate use of health system resources.
- It is important to recognize that this will not reduce costs; in fact, the opposite is more likely to occur. However, in properly designed systems, these costs can be effectively managed.

Apart from the foregoing issues, it may be observed that:

- There is no forum for effective planning of health services in Detroit. Various entities that have played this role in the past have all disappeared for lack of support. As a result, planning remains institution or agency based, with a subsequent lack of coordination and cooperation.
- The state has not pursued the full range of opportunities to enhance system development. For example, Michigan is one of the few states that failed to pursue a HRSA state planning grant for the development of services to the uninsured, a process that has led to numerous creative experiments and demonstrations around the country.

DATA SOURCES AND NOTATIONS

Table 1: Population Trends
Source: U.S. Census Bureau

Table 2: Median Household Income, 1999
Source: U.S. Census Bureau

Table 3: Health Status Measures, 2000 - 2001
Source: Michigan Department of Community Health, various documents

Table 4: Recent Hospital Closures in Detroit
Source: Southeast Michigan Health & Hospital Council

Table 5: Patient Origin Patterns/Inpatient, 1996 and 2001
Source: Michigan Inpatient Data Base

Table 6: Percent of Population Medically Underserved, 2000
Source, data for Counties: Primary Health Care *Profile of Michigan* Data Book February 2002

Table 7: Preventable Hospitalizations Per 10,000 Population, 2000
Source: Michigan Department of Community Health

Table 8: Community Coverage Mix, 2000
Source, data for Detroit: Henry Ford Health System
Source, data for Counties: Primary Health Care *Profile of Michigan* Data Book Feb. 2002

Table 9: Patient Mix as Percent of Patient Services, 12/01 – 6/02
Source: Medicare Cost Report and Medicaid DSH data

- Does not include data related to Hospital Based Units (HHAs, SNFs)
- Does not include data related to other operating components of the health system
- Medicare data does not include Medicare MCO data
- Title XIX data includes Title XIX MCO data

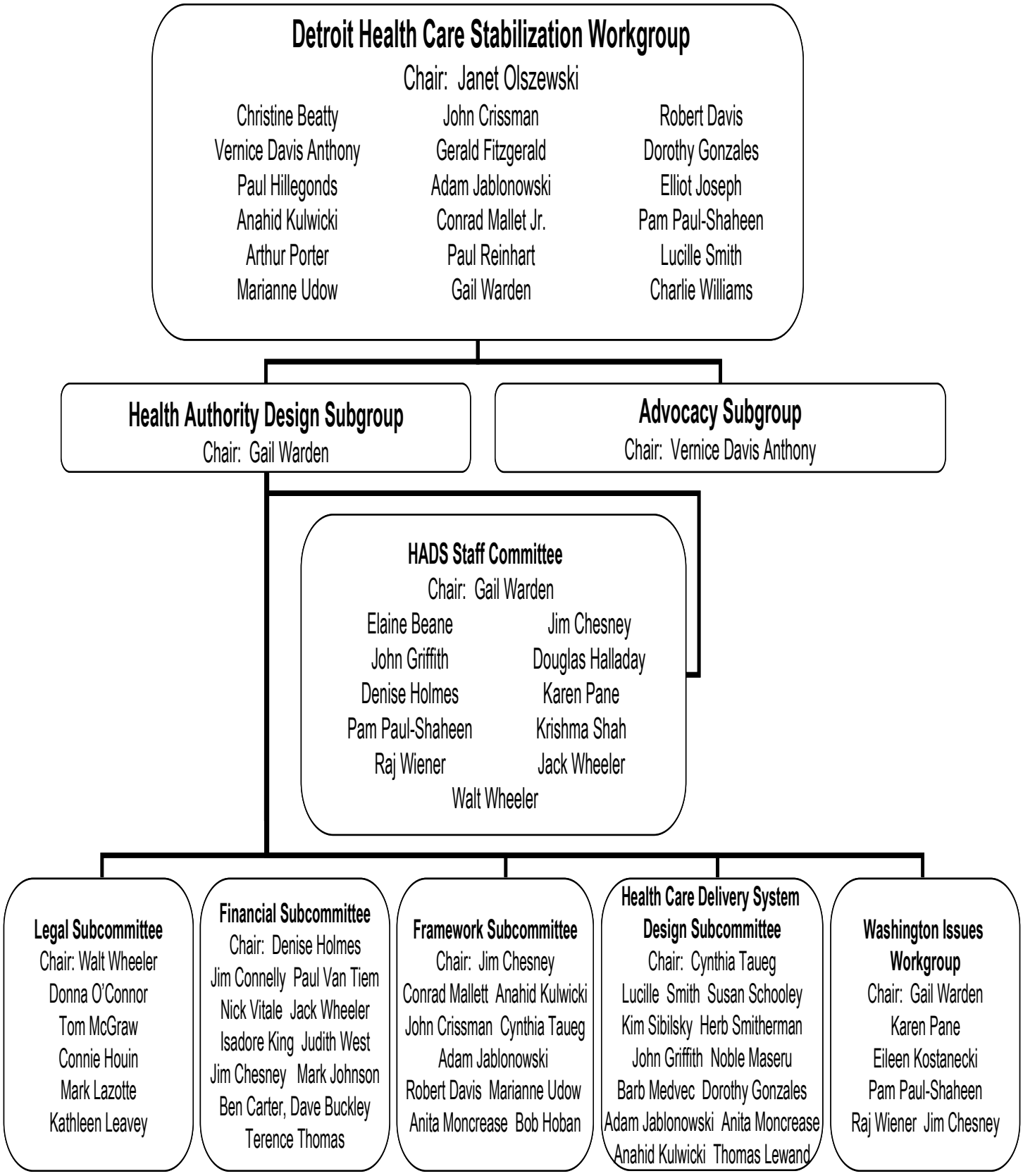
Table 10: Selected Per Capita Cost Comparisons
Sources: Medicare AAPCC Reports, Michigan Department of Community Health Medicaid Cost Model Summaries July 1998 – June 1999

Table 11: Hospital Efficiency Indicators, 2001
Source: AHA Guide 2003

Table 12: Average Hospital Lengths of Stay, 2000
Source: Michigan Department of Community Health

Note: Analysis of data pertaining to Detroit hospitals excludes its children's, veterans, rehabilitation, psychiatric, and ventilator-dependent facilities.

Organizational Structure
Health Authority Design Subgroup



Detroit Health Care Stabilization Workgroup Roster

Christine Beatty
Chief of Staff
Mayor's Office
2 Woodward Ave.
Detroit, MI 48226

John Crissman
Dean
School of Medicine - Wayne State University
540 E. Canfield
1241 Scott Hall
Detroit, MI 48201

Robert Davis
Director
Governor Granholm's Southeast Michigan Office
Cadillac Place
3022 W. Grand Boulevard
Detroit, MI 48209

Vernice Davis Anthony
President & CEO
Greater Detroit Area Health Council
333 West Fort St.
Suite 1230
Detroit, MI 48226

Gerald Fitzgerald
President & CEO
Oakwood Health Care Inc.
1 Park Lane Blvd.
Suite 1000 E
Dearborn, MI 48126

Dorothy Gonzales
Director
Wayne County Health and Human Services
600 Randolph
Suite 360
Detroit, MI 48226

Paul Hillegonds
President
Detroit Renaissance
600 Renaissance Center
Suite 1760
Detroit, MI 48243

Adam Jablonowski
Executive Director
Wayne County Medical Society
3031 W. Grand Blvd.
Suite 645
Detroit, MI 48202

Elliot Joseph
President & CEO
St. John Health System
28000 Dequindre
Warren, MI 48092

Anahid Kulwicki
Director
Wayne County Department of Public Health
33030 Van Born Rd.
Wayne, MI 48184

Conrad Mallett, Jr
Executive Vice President & CAO
Detroit Medical Center
Harper University Hospital
3990 John R.
1-Brush South
Detroit, MI 48201

Janet Olszewski
Director
Michigan Department of Community Health
320 S. Walnut
Lansing, MI 48913

Pam Paul-Shaheen
Health and Human Services Policy Advisor
Governor Granholm's Office
Public Policy Office
George W. Romney Building
111 S. Capitol Ave
Lansing, MI 48933

Arthur Porter
President & CEO
Detroit Medical Center
Harper University Hospital
3990 John R
1-Brush South
Detroit, MI 48201

Paul Reinhart
Deputy Director
Medical Services Administration
MDCH
400 S. Pine
Capitol Commons Center, 7th Floor
Lansing, MI 48933

Asha Shajahan
MLDP Intern
Governor's Office for Southeast Michigan
Cadillac Place - 14th Floor
3022 W. Grand Boulevard
Detroit, MI 48202

Lucille Smith
Voices of Detroit Intiative
4201 St. Antoine
Detroit, MI 48201

Terence Thomas, Sr.
Sr. Vice President External Affairs
St. John Health System
28000 Dequindre
Warren, MI 48092

Marianne Udow
Senior Vice President
Blue Cross Blue Shield of Michigan
600 Lafayette East
Mail Code 2110
Detroit, MI 48226

Gail Warden
President & CEO
Henry Ford Health Systems
1 Ford Place
Detroit, MI 48202

Charlie Williams
Assistant County Executive
Wayne County
600 Randolph
Suite 107
Detroit, MI 48226

Alternate
Bettie Buss
Director of Policy Projects
Detroit Renaissance
600 Renaissance Center
Suite 1760
Detroit, MI 48243

Alternate
James Chesney
Director, Public Policy Initiatives
Henry Ford Health Systems
1 Ford Place
3C
Detroit, MI 48202

Alternate
Deborah Ebers
Consultant
Greater Detroit Area Health Council
333 West Fort St.
Suite 1230
Detroit, MI 48226

Alternate
Robert Hoban
Senior Vice President
St. John Health System
28000 Dequindre
Warren, MI 48092

Alternate
Mark Johnson
Vice President
Blue Cross Blue Shield of Michigan
600 Lafayette East
Mail Code J-744
Detroit, MI 48226

Alternate
Edith Killins
Deputy Director
Wayne County Health & Human Services
600 Randolph
Suite 360
Detroit, MI 48226

Alternate
Adrienne Redden
Detroit Medical Center
6071 W. Outer Drive
Detroit, MI 48235

Alternate
Herbert Smitherman, Jr.
Assistant Professor, Internal & Community Med.
School of Medicine - Wayne State University
4201 St. Antoine
9C - University Health Center
Detroit, MI 48201

Alternate
Nick Vitale
CFO
Detroit Medical Center
Harper University Hospital
3990 John R
1-Brush South
Detroit, MI 48201

Consultant
Denise Holmes
Assistant Dean for Government Relations and Outrea
Michigan State University
College of Human Medicine
A117 East Fee Hall
East Lansing, MI 48824

Staff
Elaine Beane
Director
Center for Advancing Community Health
Michigan Public Health Institute
2436 Woodlake Dr.
Suite 300
Okemos, MI 48864

Staff
Eileen Kostanecki
Health and Human Services Advisor
444 North Capitol Street
Suite 411
Washington, DC 20001

Staff
Walter Wheeler
Director, Bureau of Health Systems
Department of Consumer and Industry Services
Fifth Floor, Williams Building
PO Box 30664
Lansing, MI 48909

Detroit Health Care Advocacy Subgroup Membership

Christine Beatty
Chief of Staff
Mayor's Office
2 Woodward Ave.
Detroit, MI 48226

Doug Halladay
Consultant
Douglas R. Halladay & Associates
Henry Ford Health System
One Ford Place
Room 4AB63
Detroit, MI 48202

Robert Davis
Director
Governor Granholm's Southeast Michigan Office
Cadillac Place – 14th Floor
3022 W. Grand Boulevard
Detroit, MI 48209

Conrad Mallett, Jr
Executive Vice President & CAO
Detroit Medical Center
Harper University Hospital
3990 John R.
1-Brush South
Detroit, MI 48201

Facilitator
Vernice Davis Anthony
President & CEO
Greater Detroit Area Health Council
333 W. Fort St.
Suite 1230
Detroit, MI 48226

Lucille Smith
Executive Director
Voices of Detroit Initiative
4201 St. Antoine, UHC, 9C
Detroit, MI 48201

Health Authority Design Subgroup

Adam Jablonowski
Executive Director
Wayne County Medical Society
3031 W. Grand Blvd.
Suite 645
Detroit, MI 48202

Anahid Kulwicki
Director
Wayne County Department of Public Health
33030 Van Born Rd.
Wayne, MI 48184

Arthur Porter
President & CEO
Detroit Medical Center
Harper University Hospital
3990 John R
1-Brush South
Detroit, MI 48201

Barbara Medvec
Chief Nursing Officer
Oakwood

Connie Houin
VP Corporate Legal Services
St. John Health
28000 Dequindre
Warren, MI 48092

Cynthia Taueg
Vice President
St. John Health System
28000 Dequindre
Warren, MI 48902

Elliot Joseph
President & CEO
St. John Health System
28000 Dequindre
Warren, MI 48092

Gail Warden
President & CEO
Henry Ford Health Systems
1 Ford Place
Detroit, MI 48202

Isadore King
President & CEO
The Wellness Plan
2875 W. Grand Blvd.
Detroit, MI 48202

John Crissman
Dean
School of Medicine - Wayne State University
540 E. Canfield
1241 Scott Hall
Detroit, MI 48201

Lorenzo Lopez
Director
Wayne County Health and Human Services
600 Randolph, Suite 360
Detroit, MI 48226

Lucille Smith
Voices of Detroit Intiative
4201 St. Antoine
Detroit, MI 48201

Marianne Udow
Senior Vice President
Blue Cross Blue Shield of Michigan
600 Lafayette East
Mail Code 2110
Detroit, MI 48226

Noble Maseru
Public Health Director
City of Detroit Health Department
1151 Taylor St.
Detroit, MI 48202

Pam Paul-Shaheen
Health and Human Services Policy Advisor
Governor Granholm's Office
Public Policy Office
George W. Romney Building
111 S. Capitol Ave
Lansing, MI 48933

Paul Reinhart
Deputy Director
Medical Services Administration
MDCH
400 S. Pine
Capitol Commons Center, 7th Floor
Lansing, MI 48933

Robert Davis
Director
Governor Granholm's Southeast Michigan Office
Cadillac Place-14th Floor
3022 W. Grand Boulevard
Detroit, MI 48209

Terence Thomas, Sr.
Sr. Vice President External Affairs
St. John Health System
28000 Dequindre
Warren, MI 48092

Vernice Davis Anthony
President & CEO
Greater Detroit Area Health Council
333 West Fort St.
Suite 1230
Detroit, MI 48226

Alternate
Adrienne Redden
Detroit Medical Center
6071 W. Outer Drive
Detroit, MI 48235

Alternate
Anita Moncrease
City of Detroit Health Department
1151 Taylor St.
Detroit, MI 48202

Alternate
Conrad Mallett, Jr
Executive Vice President & CAO
Detroit Medical Center
Harper University Hospital
3990 John R.
1-Brush South
Detroit, MI 48201

Alternate
Deborah Ebers
Consultant
Greater Detroit Area Health Council
333 West Fort St.
Suite 1230
Detroit, MI 48226

Alternate
Edith Killins
Deputy Director
Wayne County Health & Human Services
600 Randolph
Suite 360
Detroit, MI 48226

Alternate
Herbert Smitherman, Jr.
Assistant Professor, Internal & Community Med.
School of Medicine - Wayne State University
4201 St. Antoine
9C - University Health Center
Detroit, MI 48201

Alternate
James Chesney
Director, Public Policy Initiatives
Henry Ford Health Systems
1 Ford Place
3C
Detroit, MI 48202

Alternate
Mark Johnson
Vice President
Blue Cross Blue Shield of Michigan
600 Lafayette East
Mail Code J-744
Detroit, MI 48226

Alternate
Robert Hoban
Senior Vice President
St. John Health System
28000 Dequindre
Warren, MI 48092

Consultant
Denise Holmes
Assistant Dean for Government Relations and Outrea
Michigan State University
College of Human Medicine
A117 East Fee Hall
East Lansing, MI 48824

Consultant
John Griffith
Professor of Health Management & Policy
School of Public Health
University of Michigan
M3202, SPH II 2029
Ann Arbor, MI 48109

Consultant
Patricia Terrell
Principal
Health Management Associates
180 North LaSalle St.
Suite 2305
Chicago, IL 60601

Consultant
Thomas McGraw
Dykema Gossett
400 Renaissance Center
Detroit, MI 48243

Staff
Elaine Beane
Director
Center for Advancing Community Health
Michigan Public Health Institute
2436 Woodlake Dr.
Suite 300
Okemos, MI 48864

Staff
Walter Wheeler
Director, Bureau of Health Systems
Department of Consumer and Industry Services
Fifth Floor, Williams Building
PO Box 30664
Lansing, MI 48909